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Concurrent Sessions

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CBO Evaluation Guidance

Facilitators: Alan Friedlob, Qairo Ali
CDC Representatives: Francisco Sy, Winifred King
Health Department Peer: Madeline Shea
CBO Peer: Claudia Montagne

The focus of this session was the CBO Evaluation Guidance and its direct relationship to the Health Department Evaluation Guidance. Discussions were around how to coordinate CBO evaluation guidance with existing data systems and data collection procedures and other issues brought up by the session participants.

Alan Friedlob, Facilitator
Director of the Citizens Science Committee

Alan Friedlob said that for the past year he has worked as an independent consultant for the Program Evaluation and Research Branch, primarily working on issues related to CBO evaluation and evaluation guidance. He spent about 20 years in public health service, and at his last post he was the Chief of Program Evaluation and Research in the Division of STD Prevention for CDC. After he left CDC, he worked with the state of Florida in the development of their first HIV evaluation plan. So, he has perspectives – both from the CDC side and also from trying to work with people grappling with some material. He then introduced the Guidance and gave an outline of some of the things that might be useful to participants:

How was this developed?

It was developed over a seven-month period beginning in November with a work group (Carlos, Claudia and Maddy were in the work group). The group met through once-a-week conference calls for about 14 weeks. He pointed out the list of work group members on page 22 of the conference manual, and acknowledged Huey Chen for his initiative and vision for seeing the need for this type of material that could support both reporting and evaluation activities from directly funded CBO's, and also provide additional information that would supplement the implementation of the health department guidance.

What is it?

The work group's charge was to make it consistent with the health department guidance. By using the reporting forms that participants' are familiar with, they have created a manual with a Q&A formatted "how-to" reference to assist CBO's supported under program announcements 99047, 091, 092, 094, 096, 0023, 0100, 0163 with reporting aggregate process monitoring data to CDC on a quarterly basis. It relates to the directly funded CBO's.

How many of these entities exist?

The most recent data that he has gotten from CDC's database is that there are roughly 1550 CBO's in the database, and that about 85% are funded through the pass-through funds. The other 15% are either funded directly through CDC or fall in the dual category of receiving direct and indirect funds. For the 85%, the guidance provides tools and suggestions for methods that will complement their extensive efforts to date. He has learned about the investment that many health departments have already made in implementing the guidance and figuring out ways to make it work with the resources available to the states/local jurisdictions. For those organizations that aren't directly funded, there is information that would be helpful for those efforts.

Specific areas of interest:

- ❑ In the Discussion of Intervention Plans, they emphasize the use of informal theory or the logic model as the principle means of providing information on intervention plans. This is coming from the work group – from a discussion about the classification of behavioral science and critical examination of the health department guidance. A consensus was reached on the use of logic models being meaningful for program evaluation, program monitoring and dialogue between project officers at the state/federal level.

- ❑ Measurement of Resource Allocation across intervention types – how to approach that in a non-profit setting. The forms have a section for "expenditures by intervention type" and that they suggest an approach for how CBO's would make that allocation.

- ❑ Provide for each of the eight intervention categories is a "gold standard" for client level data collection forms. They examined over 100 different forms from different organizations, and they provide the forms as a suggested standard to compare the data collection forms that their contractors and CBO's are currently using – as a method of dialogue, not a prescriptive method. Person-level data ultimately drives this and they are interested in people receiving services.

- ❑ They provide detailed approaches to measuring the audience for health communications interventions – based on media industry standards. He gave an example from the guidance, "Provide an estimate of 150,000 people exposed to this measure." Francisco Sy said that if the CBO is heavily invested in using media, where media is the core of their intervention and dollars are flowing to that intervention, it is reasonable to use industry standards to measure audiences more specifically. Though it might be "overkill" they would find ways to do that.

- ❑ Detailed clarification of the taxonomy for community level interventions are included (e.g., examples of community mobilization, structural adjustments and social marketing). There are also appendices that provide user-friendly definitions of behavioral research theories applying to HIV prevention, and questions to ask when conducting a process monitoring process evaluation of community collaboration. They provide a series of questions that could be used to monitor the process of community collaborations.

Alan Friedlob then stated that the desired outcome for the session is that participants would have a hands-on review of parts of the guidance because each group would break down the guidance and review it. He also said he wanted to hear thoughts from participants based on their experience with the health department guidance and on effective ways to extend training to CBO's - for example, measuring the actual expenditures related to the services provided.

Discussion Summary:

- ❖ Regarding multiple session GLI's, PCM and ILI, where clients are seen for multiple times, a question was raised regarding what to do if participation in an intervention straddles more than one reporting quarter. When should the CBO report it? Alan Friedlob responded that this stems back to using an encounter data form, which CDC has not required. States vary in how they use an encounter level form and whether they use personal level identifiers for ILI, GLI and PCM. He said since CDC hasn't required it, the ability to report that way ultimately goes back to the foundation – individual client level data.

- ❖ Regarding an agency funded by both the state health department and directly funded by CDC, an inquiry was posed as to how they will ensure that interventions are not being

"double-counted" (reported both to state health and CDC). Alan Friedlob said when he put the manual together, he caught some of the issues, such as expenditures incurred in certain quarters. He said these types of nuance questions are very important because they will affect the quality of the data. The CBO guidance focuses on aggregating CBO performance by program announcement – an identification that those intervention activities are associated with a particular program announcement. This will allow them to be carved out from that dual funding stream.

- A question was raised about why they did not just develop one general guidance for the health departments and CBO's that guide planning, monitoring and evaluation of programs at the local levels. Alan Friedlob this was the type of policy question that an organization such as NASTAD could address with CDC, but that it was inappropriate for them to give a response to it since they are the analysts who implement that policy.

Francisco Sy, CDC Representative
CDC, Program Evaluation Research Branch

Francisco Sy gave a brief overview of the CBO guidance. He said that one year previously, he was on the other side of the fence when he worked with the University of South Carolina, the South Carolina Health Department and various CBO's in the state. Now that he is on the other side, he realizes all of the work that must be coordinated with participants – one of which is the CBO Guidance. He made the following points:

Why do we need program evaluation?

- Accountability
- Program improvement for CBO's

Two general types of program evaluation:

- Process monitoring that would lead to process evaluation ("How is the prevention program implemented?").

- Outcome monitoring that would progress to outcome evaluation ("Does the program reduce clients' risk behavior?").

CBO's funded under program announcement:

- 0023 – use approximately three to five percent of funding for program evaluation and outcome monitoring of intervention activities.

- ❑ 00100 – use approximately five percent of funding for training, quality assurance, program monitoring and evaluation.

CBO evaluation guidance:

Volume 1: Evaluating intervention plans and implementation process in CBO's.

- ❑ *Unit 1* is titled *Evaluating Intervention Plans and Implementation Process Guidance*. It's purpose is to provide CBO's with a format and guidance for collecting and reporting process data. The content is identical to chapters 3 & 4 of the Health Department Guidance. It was developed with the health department, CBO's and consultants, and it's been pilot-tested in seven states. It's status is that it was to be submitted to OMB for clearance several months ago, and will probably be approved in July of 2001. Drafts were distributed to CBO grantees in December of 2000.

- ❑ *Unit 2* is a *How-to Manual*, and it's purpose is to provide additional information and instruments for CBO's to collect and use the process monitoring data. The content was developed by a work group of eight CBO representatives, four health department representatives, four CBA representatives and CDC staff, using weekly conference calls. The status is that drafts are now available for feedback.

Volume 2: Outcome monitoring (work in progress)

- ❑ *Unit 1* is Outcome Monitoring Guidance, and it's purpose is to provide CBO's with a format and guidance in assessing the effectiveness of their efforts. It contains outcome indicators and outcome monitoring forms developed jointly with CBO's. The status is that the draft is under review by CDC.

- ❑ *Unit 2* is a How-to Manual, and it's purpose is to provide additional information and instruments for CBO's to collect and use outcome monitoring data. The content was developed jointly with CBO's, and the status is that a draft manual is ready for pilot testing.

Francisco Sy agreed with what Alan Friedlob said about making sure that it is consistent with the health department guidance. The only new addition is a piece on outcome monitoring and that the rest of the foundation was laid by the health department guidance.

Discussion Summary:

- ❖ An inquiry was posed as to how (CBA) providers will be integrated in supporting CBO's with TA for the guidance. Francisco Sy said that (CBA) providers will be funded and sub-contracted in the future to help with regional training for the CBO Guidance.

- ❖ An inquiry was posed as to what the outcome monitoring volume includes (e.g., tools, recommendations for implementation). Francisco Sy said that they are in an early draft phase for the outcome monitoring form. They are looking at such outcome indicators as condom use and decreasing number of sexual partners.

- ❖ A participant inquired as to how the health department will be involved in training/data collection by directly funded CBO's (gap analysis). Francisco Sy said there would be four prevention centers involved with this – the four CBA providers, CDC, SATeam and eventually the health department.

Winifred King
CDC Representative
Group Activity

Winifred King described the purpose of the group activity which was to have the participants become "experts" in at least one aspect of the guidance, and to receive a thorough overview of the other sections at once. The participants were asked to:

- ❑ Review the section assigned to their group and become "experts" on that section;
- ❑ Discuss the major highlights of the section and the usefulness of collecting these data; and
- ❑ Put a report together to present to the entire group.

The group presentations are as follows.

Group 1 - Intervention Plans:

Highlights

- ❑ Provides definition of intervention plans.

- ❑ Includes information needed to complete intervention plans – concrete listing.

- ❑ Assists with how to estimate your activities (staffing, external challenges, past performance, data from other CBO's).

- ❑ Provides description of science and the need to have it theory based. Appendix includes

descriptions of various behavioral theories. *Should also list the justification for population and setting (will be updated for next draft).

- ❑ Provides information on how to develop a logic model that links activities and outcomes.
- ❑ Includes web addresses for finding out about the construction of a logic model.
- ❑ The group agreed that they were glad not to be overwhelmed with excessive information.

Usefulness

- ❑ Intervention plans provide realistic direction to CBO's.
- ❑ They provide a focus for the CBO's and health departments to measure progress against.
- ❑ They validate the programs by linking them to theory (instead of just doing what's always been done).
- ❑ They give long-term ability to project services and activities – which will lead to an increased ability to attract funding from other sources.
- ❑ They help to measure program effectiveness and possible need for modifications.

TA Needs

- ❑ Huge need for TA for CBO's to do intervention plans. The need is especially great up front – with planning to do interventions.
- ❑ Need for training on behavioral science behind interventions.
- ❑ Continued training on collecting information/data and collection tools.

Group 2 – Process Monitoring

Highlights

- ❑ Great definitions – the common sets of definitions to getting the core data is essential.

Usefulness

- ❑ Pages 14-15 give reasons why this is a good idea – to share with CBO's.

TA Needs

- ❑ Asking clients about demographic data, as opposed to guessing what it is, is a challenge for some. Some outreach workers/group level guess at the demographics based on surnames or looks. Getting CBO's to ask the question – and not assume – will have to be emphasized.

- ❑ More and more individuals have multiple risks – how to pick just one? Would data be lost in picking the one risk? Emerging needs information could be lost.

- ❑ One page summary on volunteers is great for CDC, but not for CBO's (they would not be able to fill out the form). A challenge is giving them a breakdown of what number goes in that hole – similar to IRS worksheets. Different volunteers give different types of services to CBO's. Dollar amounts are hard to determine without breaking it out.

- ❑ Summary budget sheet is a good idea if you break out where the numbers come from. CBO's need step by step help – it's overwhelming.

- ❑ A comment was made that the CDC is not looking for numbers of volunteers on the forms, but volunteer hours.

Group 3/6 – Individual and Group Level Interventions

(Groups 3 and 6 were combined).

Highlights

- ❑ Compared to the health department manual, the way that ILI and GLI elements are defined is much better.

- ❑ Very clear in the components for GLI that there must be a skills teaching component.

- ❑ Directions on reporting HCPI were very clear – better than HD guidance.

- ❑ Ultimate reporting forms are the same – can do comparisons/gap analysis.

- ❑ Tracking from using unique identifiers to track people across ILI and GLI was much clearer than the HD guidance.

Usefulness

- ❑ Since the forms are the same, can do gap analysis.
- ❑ Easier to identify a set of needs via referrals and can also begin to discover a lack of services.
- ❑ CBO can see that it's okay that they can't do everything – they can reflect on capacity.

TA Needs

- ❑ Divergence between the definition of PCM for ILI and actual PCM (pg. 29 compared to pg. 38).
- ❑ Reporting of data from GLI, ILI and PCM when it straddles a reporting quarter.
- ❑ Might need TA on how to approach state health departments.
- ❑ TA on program design to coincide with evaluation guidance.
- ❑ CBO training on how to use and implement guidance.
- ❑ Training on how to set up data management systems to track ILI and GLI more effectively.

Group 4 – Prevention Case Management Interventions

Highlights

- ❑ Highlights the six key elements of PCM (risk assessment, developing a client center plan, doing referrals).
- ❑ States that typically this is prioritized for persons living with HIV, although could also be for high-risk negatives.
- ❑ Highlights actively disclosing HIV status as part of reporting mechanism.
- ❑ Highlights talking to people about their partners but doesn't talk about linkages to PCRS.
- ❑ Talks about what can be counted as a client served – but doesn't address whether locating = serving.

- ❑ Says that the service can be done in person, electronically or in writing – would urge the reconsideration of PCM in writing.

- ❑ Supplemental forms do not include data relating to all six PCM elements (backup forms don't meet all of the purposes needed for aggregate form).

Usefulness

- ❑ Addresses if clients match targets.

- ❑ Addresses a multi-level approach to risk assessment.

- ❑ Includes client background information (living situation, living conditions).

- ❑ Ties into Ryan White – shows accountability, but complicates cost determination for personnel (which part is devoted to care and which part to prevention?).

TA Needs

Need to have the following skills:

- ❑ Needs assessment
- ❑ Resource inventory
- ❑ Gap analysis
- ❑ Risk assessment
- ❑ How to develop client center plans for risk reduction
- ❑ How to identify/develop appropriate ways to work with clients around PCM (protecting them and their partners).
- ❑ How to conduct a PCM session
- ❑ Cultural sensitivity/appropriateness
- ❑ How to make appropriate referrals to follow up

Groups 5/6

Group 5 was eliminated. Groups 3 and 6 combined in Individual and Group Level Interventions.

Group 7 – Street and Community Outreach Interventions

- ❑ This group first looked at definitions focusing on active and face-to-face educational interventions – approaching people in public places and venues (streets, parks, homeless shelters, drop-in centers, bathhouses and public sex environments). Active street outreach vs. venue based outreach (bathhouses, gyms etc.).

- ❑ What is HIV prevention and what isn't? The presenter said that a CBO going to a gay bar or other venue and dropping off promotional materials or condoms with someone else passing them out – that is not considered outreach. True outreach intervention is where the CBO's actual staff passes out the materials or condoms.

- ❑ How do you define HIV prevention materials? Some examples given were: condoms, safer sex kits, promotional items, safer injection kits, brochures and materials.

- ❑ How should you collect outreach data?

- ❑ What types of data are collected?

Usefulness

- ❑ Relative cost of outreach would make it potentially useful – less expensive than other possible interventions.

- ❑ Realistic approach to prevention.

- ❑ Outreach workers have face-to-face contact with those out in the community – can determine what is really going on.

- ❑ Neediest clients might not necessarily be seen in other HIV prevention venues (might be embarrassed – married, injection drug users only worried about getting next score).

- ❑ Immediacy – the prevention activity comes to these clients, rather than them having to go someplace for it.

- ❑ It's a measurement of program effectiveness and an accepted approach – CBO's typically have experience with outreach.

TA Needs

- ❑ How to standardize definitions that are used and how the outreach workers approach/interact with clients.
- ❑ How to measure effectiveness.

- ❑ How to collect/report data.
- ❑ How to train and supervise staff.
- ❑ How to coordinate with other programs (STD, CARE) – coordination leads to increased effectiveness.

Group 8 – Health Communication & Public Information/Community Level Interventions

Highlights

- ❑ This group had high praise for the document and that they are excited about it.
- ❑ Definitions of terms and provisions of examples.
- ❑ Q&A format is realistic (easy questions to more complex questions).
- ❑ It's broken down into specific interventions.
- ❑ It's straightforward and easy to read.

Usefulness

- ❑ Will help define where the intervention is going.
- ❑ Will help the health department define even more the direction of the evaluation.

TA Needs

- ❑ Look at the data forms and examples to see how they are linked and to help the department and CBO's use the forms.

- ❑ Gap: Community level interventions are better defined in the CBO guidance than in the evaluation guidance, Volume 1. Can that be equalized?